Opioid analgesia has been employed for centuries for management of pain. Advances in opioid design (from drugs derived from opium to synthetic drugs), as well as expansion and innovation in delivery methods, have increased their efficacy for aggressive pain management. Traditional oral and intravenous delivery methods have been supplemented with intrathecal, transdermal, and oral transmucosal administration; nasal sprays; and patient-controlled dispensing systems. These varied administration methods have contributed to the continued expansion of opioid use in both inpatient and outpatient settings (Lanier & Kharasch, 2009). Despite the therapeutic benefit of this medication class, short-term and long-term risks exist. The prevalence of opioid misuse and dependence has increased. Increased availability of opioids also allows diversion of prescription opioids to recreational users.

Abuse and Dependence

In 2008, 22.2 million Americans over age 12 had substance abuse or dependence problems, representing about 8.9% of the population (Substance Abuse & Mental Health Services Administration [SAMHSA], 2009). Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following: 1) failure to fulfill major role obligations; 2) physically hazardous use; 3) substance-related legal problems; and 4) use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. (American Psychiatric Association [APA], 2000, p. 114)

Criteria for dependence include a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following: 1) tolerance (requires increased amounts of the substance to desired effect or diminished effect with use of the same amount of the substance); 2) withdrawal (characteristic withdrawal syndrome for the substance or taking the substance to relieve or avoid withdrawal symptoms); 3) the substance is often taken in larger amounts or over a longer period than intended; 4) unsuccessful efforts to control substance use; 5) time spent on activities necessary to obtain, use, or recover from effects of the substance; 6) reduced psychosocial functioning; and 7) continued use despite known risks. (APA, 2000, p. 110)

Both dependence and abuse criteria must occur within a 12-month period; a person can be abusing a substance or dependent on a substance but not both at the same time (APA, 2000). According to SAMHSA (2009), over 6.2 million people over age 12 have used prescription analgesics or psychotherapeutic drugs in the past month; 1.7 million report dependence on analgesics. The number of new users of heroin and analgesics in the same population during the same time frame was 114,000 and 2,176,000 respectively. In addition, an estimated 75 million Americans who suffer from chronic pain may use prescribed opioids because pain impairs their daily activities (Peppin, 2009). Pseudoaddiction is observed in patients who are opioid-dependent and exhibit drug-seeking behaviors when their pain management needs are not met. As soon as their needs are met, usually when their effective treatment regimen is resumed, drug-seeking

Instructions for Continuing Nursing Education Contact Hours appear on page 36.
Treatment for Opioid Dependence

Despite the prevalence of substance abuse and dependence, only 2.3 million users received treatment as hospital inpatients, in an emergency department, at a drug or alcohol rehabilitation center or mental health facility, or through a self-help group within the past 12 months (SAMHSA, 2009). Almost 21 million Americans, many of whom use opioids, remain in need of treatment.

Traditional methods for treating opioid dependence include psychosocial as well as psychopharmacological modalities. Because opioid addiction is difficult to manage with psychosocial therapy alone (e.g., individual and group therapy), treatment often includes pharmacotherapy. Pharmacotherapy can be initiated at various stages of active addiction and also can be employed to prevent relapse (Ross & Peselow, 2009). Self-help groups (12-step programs such as Narcotics Anonymous) are resources for persons in recovery for opioid addiction because they provide social support that reinforces positive behavioral changes (Chen, 2006). Whereas treatment usually focuses on active addiction, services related to prevention and early detection may be of more benefit to the individual and the nation (Snow & Delaney, 2006).

Methadone is the most common opioid replacement therapy. It reduces illicit opioid use, increases treatment retention, and can be prescribed for detoxification or maintenance therapy. It is a full opioid agonist that can be dosed daily due to its long half-life (24-36 hours), but strict regulations regarding dispensing at designated treatment centers limit opioid-dependent patients’ options (Ross & Peselow, 2009).

Another more recent, promising pharmacologic therapy is buprenorphine, a long-acting, partial opioid agonist. Buprenorphine monotherapy (Subutex®) and buprenorphine (Suboxone®) in combination with naloxone to prevent parenteral abuse are sublingual formulations approved for outpatient treatment of opioid dependence (Ross & Peselow, 2009). The sublingual preparation delivers buprenorphine through the oral mucosa; naloxone will not affect the actions of buprenorphine unless the individual attempts to crush the pill for snorting or injection. In the event this occurs, naloxone will block the effects of buprenorphine and cause withdrawal.

Lastly, the opioid antagonist naltrexone (ReVia®) prevents relapse through a long-acting opioid receptor blockade. It has a favorable safety profile, and is being evaluated for a sustained release injection. However, research indicates naltrexone treatment programs have a high dropout rate due to patient preference for replacement therapy (Ross & Peselow, 2009).

These medications allow patients to regain some quality of life while their opioid dependence is managed (Ross & Peselow, 2009). At some point, however, opioid-dependent individuals receiving pharmacologic therapy encounter non-addictions focused people or settings that place their treatment regimen and personal health at risk due to their unique pain management, medical, and psychosocial needs.

Opioid Dependence in Non-Addictions Settings

Opioid-dependent patients, whether illicit drug users or persons with chronic pain, have multiple, complicated needs including high levels of morbidity and mortality, domestic and family problems, homelessness, abuse, victimization, and unemployment (Neale, Tompkins, & Sheard, 2008). These concomitant problems often result in the patient being labeled as difficult, challenging, or even morally suspect. This labeling can affect care seeking, care delivery, and treatment. Common barriers to care include stigmatization from physicians and nurses, self-stigmatization, discrimination, frequent need for services, fear and anxiety about withdrawal, and lack of professional skill in identifying and addressing substance abuse. These vulnerable and disadvantaged patients are found to access health care more frequently then non-users and often have one or more drugs in their system at the time of service (Henderson, Stacey, & Dohan, 2008). Advanced provider skill is required to determine their chief complaint (usually apart from issues of substance dependence) and other “relevant aspects of their clinical presentation in a short time and often with over-taxed resources” (p. 1337).

A common misdiagnosis of narco tic overdose is assigned when treating opioid-dependent patients, sometimes despite clinical evidence that other etiologies for mental status changes such as hypotension exist (Peppin, 2009). Commonly, the patient's condition deteriorates until he or she is in “florid opioid abstinence syndrome with tachycardia, nausea, vomiting, diaphoresis, hypertension, and dramatically increased pain” (p. 495). This contributes to reluctance on the part of the opioid-dependent patient to access generalized services because of anxiety and fear he or she will be allowed to go into withdrawal (Neale et al., 2008).

Care providers also have fears and concerns related to treating patients with opioid dependence, including the potential for abuse, diversion, deception, and disciplinary consequences. However, they rarely mention concerns about the potential for ineffective management of patients’ pain. Many providers are concerned with prescribing opioids due to patients’ high-risk profile, and the ambiguity of treating opioid-dependent patients with opioids for pain further amplifies this fear. Similarly, patients in recovery from opioid dependence may fear taking pain medications and self-impose under-medication, which neither mitigates pain perception nor increases ability to function (Berg, Arnst, Sacaju, & Karasz, 2009). Substance abuse is a disease of shame, and some patients fail to mention or try to hide their opioid dependence because of self-stigmatization (Kanter, Rusch, & Brondino, 2008). Discovery of this important fact often occurs by accident, sometimes long after preventable complications have occurred. Rectifying
issues related to treatment of opioid-dependent patients in general health care settings is an enormous undertaking that requires multidisciplinary involvement and a willingness to abandon traditional frameworks that assign stigma, fail to educate providers appropriately, and lack protocols for early identification and intervention of substance dependence (Berg et al., 2009).

Stigma

This phenomenon was first described in the 1960s by sociologist Erving Goffman as a “discredited individual attribute or spoiled identity” (as cited in Henderson et al., 2008, p. 1337). Since then, a great deal of attention has been given to defining stigma, but less emphasis has been placed on addressing health-related stigma. Weiss, Ramakrishna, and Somma (2006) defined the social process of health-related stigma as one that is characterized by “exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or a group. The judgment is based on an enduring feature of identity conferred by a health problem or health-related condition and the judgment is in some way medically unwarranted” (p. 280).

Opioid-dependent patients can be considered stigma-vulnerable in that while an individual may not be stigmatized, historically the group is (Henderson et al., 2008). Further compounding the issue is the concept of self-stigma, “those same attitudes internalized and held by individuals with the stigmatized condition” (Kanter et al., 2008, p. 663). Kanter and co-authors suggested public stigma begets self-stigma, and self-stigma results in decreased care seeking. Providers in general hospital settings usually have a high level of education, but their lack of knowledge regarding substance dependence appears to underlie the stigmatizing decisions made regarding this population (Henderson et al., 2008). Simple recommendations for reducing stigma are not enough to reduce the impact stigma has on this population (Henderson et al., 2008).

Research indicates case management can improve care because it relieves the provider of some of the responsibility of treating the unique medical and social needs of this population, and may reduce frequency of visits to primary care centers such as emergency departments. Social workers trained in managing substance dependence can be assigned to patients with known substance use upon medical admission. While a case management approach appears to be cost effective, its limitations include managing and funding a program during time of scarce resources (Henderson et al., 2008). Interventions aimed at reducing stigma can focus on the problem itself (public health efforts to control substance abuse and dependence), stigmatization (educate and remediate), emotional impact on sufferers (counseling), and social policy (advocacy) (Weiss et al., 2006).

Inadequate Training

Nurses are key facilitators of positive outcomes for patients who are dependent on opioids, but nursing care for affected patients is complex due to clinical challenges and personal risk that nurses often feel underqualified to address (Ford, 2011). Several themes were identified by Ford as challenges to caring for illicit substance users, including manipulation, irresponsibility, and violence. Additional training for this patient group is needed and desired by nurses to build, or preserve, a therapeutic relationship with persons who are already at risk for discrimination in the health care system (Ford, 2011).

Addiction specialists (nursing, medicine, and other health professions), research initiatives, and support through education are central to the goal of treating substance abuse disorders (SUDs). The Association for Medical Education and Research in Substance Abuse is a multidisciplinary organization committed to health professional faculty development in substance abuse. Samet, Galanter, Bridden, and Lewis (2006) recognized adequate training for all involved in the care of opioid-dependent patients involves three major competencies: knowledge, skill, and education. First, knowledge focuses on general concepts, such as definitions and diagnostic criteria, epidemiology, psychosocial relationships, and prevention. This includes risks and protective factors, effects of other substances such as alcohol, relevant pharmacology, evaluation management to include treatment approaches and behavior modification, legal and ethical issues, and impairment of health professionals with SUDs. Second, skill competencies should include recognition of signs and symptoms, screening techniques, and prevention and motivational skills to impede the course of substance abuse and dependence. Finally, health professionals educated to recognize SUDs as treatable illnesses will care for affected persons with compassion.

Addictions nurses with specialized training, such as certified addictions registered nurses (CARNs) or advanced practice CARNs (CARN-APs), have skills matched directly to serving individuals with substance dependence. They are highly trained in recognizing and communicating with substance-dependent patients regarding the course of quality treatment. In addition, they may be recruited as leaders in institutions for educating staff and affecting change across disciplines by promoting early detection and intervention for persons with addictions (Finnell, 2002).

Screening and Intervention

Primary care physicians, nurses, and other health care providers can prevent the damage created by substance use and dependence by recognizing problems early and providing appropriate intervention. Simple, affordable standardized instruments are available, but they continue to be under-utilized (Madras et al., 2009).

In 2003, the SAMHSA initiated a screening, brief intervention, and referral-to-treatment (SBIRT) pro-
gram to promote screening and early intervention for patients with alcohol and substances in general hospital settings. The purpose of substance screening is to identify individuals who may have SUDs and determine if they require brief interventions that can be administered in general health care settings, or need referral to specialty addictions treatment providers (U.S. Department of Health and Human Services, 2008). Selected SBIRT grantees use one of several questionnaires that are administered in verbal or written form to screen patients at intake. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-question multiple-choice questionnaire developed by the World Health Organization to detect harmful/hazardous alcohol use and probable alcohol dependence (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). It has been adapted to screen for hazardous drug use (Knight et al., 2003). The Cut-Annoyed-Guilty-Eye Assessment (CAGE) is a four-item “yes-no” questionnaire that gives insight to a person’s feelings about his or her alcohol use (O’Brien, 2008). Similar to the AUDIT, the CAGE questions have been adapted to screen for drug use. Finally, the Drug Abuse Screening Test (DAST) is a 28-item self-report of problem substance abuse (Yudko, Lozhkina, & Fouts, 2007). Of the almost half million screened as part of the 2003 SAMHSA program, 22.7% of persons were positive for problematic substance abuse and subsequently evaluated to receive one of three levels of care: brief intervention (70%), brief treatment (14%), or referral to specialized treatment (16%) (Madras et al., 2009).

SBIRT grantees perform brief interventions that include motivational interviewing aimed at changing behavior, brief treatment (multiple enhanced brief interventions), and referral of identified substance-dependent patients to specialty providers. A random selection of patients with positive screening who received 6-month follow up showed a marked decrease (67%) from reported baseline drug use. Self-reports from the most at-risk patients indicated statistically significant improvements in general health, mental health, employment, housing, and criminal behavior. Regardless of the screening tool used, (AUDIT, CAGE, or DAST), selected sites reported consistent results across demographics that support implementation of widespread screening and intervention tools across the health care spectrum (Madras et al., 2009). Screening and brief interventions appear to reduce the adverse effects of substance use through early intervention before abuse becomes dependence, and expands treatment options for persons unable or unwilling to access services (Madras et al., 2009).

Conclusion

Opioid dependence and abuse continue to increase in the United States, and consequently more patients seen in generalized hospital settings have substance use disorders. The number of persons in treatment or receiving opioid maintenance therapies for their disorder is significantly lower than the number still needing treatment, and data on those who have recovered are not readily available (SAMHSA, 2009). Opioid-dependent patients may not receive quality health care due to stigma; lack of training, knowledge, and skills; poor attitudes; and underutilization of screening and brief intervention tools (Henderson et al., 2008; Madras et al., 2009). Addressing these issues in general hospital settings by training staff may reduce adverse consequences dramatically for opioid-dependent patients in general hospital settings (Madras et al., 2009).

REFERENCES


ADDITIONAL READINGS

